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FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  FCL045114	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01  B. WING: _____	(X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  WILLOW SPRINGS ASSISTED LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 HEBRON STREET HENDERSONVILLE, NC 28739		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments  Report of Biennial Construction Survey by Frank Strickland on 05/07/2015:  Based on Information gathered from DHSR database, this facility was either first licensed or submitted on 12/28/2011 as a Family Care Home. The Facility is currently licensed for six Ambulatory Residents. Therefore, this facility was surveyed for conformance with the 2005 "regulations for family care homes", and the 2009 Edition of the North Carolina State Building Code Section 421.2.  Deficiencies were cited and a Plan of Correction is required.	C 000	 <p>Replaced 4/28 &amp; 7/11 and the handrail wasnt stable. So we moved it to where the stick where in the wall. Residents state much easier to use. Facility will monitor weekly to insure safety. Documentation will reflect the monitoring</p>	
C 135	Bathroom-Hand Grips  SECTION .0300 - THE BUILDING 10A NCAC 13G .0309 BATHROOM (e) Hand grips shall be installed at all commodes, tubs and showers used by the residents.  This Rule is not met as evidenced by: 1-Based on observation, the facility has not maintained the hand grips in the Bathrooms. This will effect all residents using commodes, tubs and showers.  Findings on 05/07/2015 The hand grips are not supported properly in the shower surrounding walls for the Bathroom that is located adjacent to Room 1.	C 135		7/1/15  7/1/15

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

DATE

STATE FORM

XD4F21

If continuation sheet 1 of 1